

Colorado Region - Regional Reference Laboratory Cytology Department 303-404-4160 FAX: (303) 404-4161 11000 E. 45th Avenue

Denver, CO 80239

COMMUNITY PROVIDER & DOWNTIME FORM PAP or NonGYN & FNA REQUEST

(Use for LIS-HealthConnect unavailable or Non-KP Provider **Only**)

Order Date:	Facility & Clinic:
*Patient Name:	*KP ID#
□ *Non-KP/Community Provid	er
*Provider Name:	
*Provider Address:	
*Provider <u>FAX</u> number:	*Phone No.:
PLEASE ATTACH OUTS	SIDE CLINIC SPECIMEN ORDERS
Patient Date of Birth:	LMP
*Source (be specific):	
***Please write the source/site on the Sources/sites <u>must match</u> for specime	
☐ Pap Only ☐ HPV-Cotest for 30-65	5 year old □ ChlamGc □ HPV Only -No Pap
Clinical History:	
Clinical Diagnosis (ICD-10):	
	Lab Use only
	Number of Slides:
Pathologist:	Containers Recyd: